AUTHORIZATION TO RELEASE PATIENT INFORMATION

Name (First, Middle, Last)		(Maiden/Alias)		
Address		**City**	**State**	**Zip Code**
Date of Birth	**SSN (Last 4 Digits)**	**Phone Number**		

1. **I am the patient listed above or the legally authorized representative of the patient listed above. I request that protected health information be DISCLOSED from one of the following ProMedica entities (*check all that apply*):**

Michigan Hospitals	Ohio- Regional Hospitals	Toledo, Ohio - Metro Hospitals
☐ Bixby	☐ Defiance Regional	☐ Bay Park
☐ Charles and Virginia Hickman	☐ Fostoria	☐ Flower
☐ Coldwater Regional	☐ Memorial- Fremont	☐ Toledo
☐ Herrick Memorial		☐ Toledo Children's
☐ Monroe Regional		☐ Wildwood Orthopedic Spine Hospital
Outpatient Services	**Other**	**ProMedica Physician Group (Specify physician/group)**
☐ Radiology	☐ Home Care	Name
☐ Lab	☐ Hospice	City
☐ Total Rehab		State
☐ Wound Care	☐ Other:	
☐ Urgent Care		
☐ Hickman Cancer Center		

2. **Records to be released *(check package below and specify date range):***
Please note: If no dates specified above, the last two year of records will be released

☐ Package 1 – Pertinent Records (Discharge Summary/Physician Office Note, H&P, Procedure Reports, Consults, all Diagnostic Testing Specify Dates/Date Range:
☐ Package 2 - ProMedica Physician Group Entire Record – Specify Dates/Date Range:
☐ Package 3 - Hospital Entire Record – Specify Dates/Date Range:
☐ Package 4 - Diagnostic Tests – Specify Dates/Date Range:
☐ Package 5 – Other Records *(Please Specify):*

3. **Person/Physician/Organization authorized to RECEIVE the information:**

Name	**Company**		
	RECORDS DEPOSITION SERVICE, INC.		
Address	**City**	**State**	**Zip Code**
PO BOX 5054	SOUTHFIELD	MI	48086-5054
Phone Number	**Fax Number**		
248-357-3330	248-357-3337		

Send COMPLETED form to System HIM via email phs.him.roi@promedica.org or fax 419-479-6919. Please be aware that information sent via email is not secure and could be misdirected or intercepted in transmission.

4. **Information should be on: and delivered via:**

Electronic Delivery

☑ Secure Email REQUESTS@RECDEP.COM
☐ On-site Review (By Appointment Only)
☐ ProMedica MyChart
☐ Include Proxy(ies) Name(s): ____________________
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☐ ***CD*** **or** ☐ ***Paper***

☐ Mail to address listed in section 3
☐ Picked-up by: ____________________
(ID is required for picked- up)
☐ Fax to number listed in section 3

5. **Purpose of Release/Disclosure: (Complete Only for Third Party Requestor – Not Applicable for Patient/Patient Representative Requests)**

☐ Transfer- Physician office ☐ Substantiation of payment claims/Insurance ☑ Legal Use ☐ Personal Use
☐ Continuation of medical care ☐ Lab Monitoring ☐ Other (specify) ____________________

6. **Required Notices**

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

7. **Expiration**

In accordance with State law and unless otherwise revoked, this authorization must be presented before the expiration date of one year (Ohio) or 60 days (Michigan) from signature, unless an earlier expiration date is specified.

Note: "Does not expire", "no expiration", or "none" are not acceptable.

____ ____________________

Signature of Patient or Legally Authorized Representative **Date**

Relationship to Patient: ____________________ **Witness:** ____________________

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)

☐ Parent ☐ Durable Power of Attorney for Health Care ☐ Legally Authorized Representative
☐ Personal Representative of the Estate ☐ Other (specify and attach proof) ____________________

For ProMedica Use Only:	
☐ Records released by Office/Department-(form will be scanned into chart) ☐ Mailed ☐ Faxed ☐ Picked Up Date Processed: ____________________ Processed By: ____________________	☐ Forwarding Request to Systems HIM ROI for processing Date Forwarded: ____________________ Forwarded By: ____________________

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